Partners in Policymaking®

Year _____ Class _____

Participant Reimbursement Request

Weekend Date: _____

☐ Child Care # of hours _____@ $_____/hour $ _____*
☐ Respite Care # of hours _____@ $_____/hour $ _____*
(Cannot exceed $___/hour and enclosed form must be completed & signed by provider.)
☐ Mileage # of miles _____ @ $_____/mile $ _____

TOTAL AMOUNT OWED: $ _____

Make Check Payable To:_____
(Note: Check must be payable to Partners Class Member, not provider!)

Mail Check To:_____

_____

Signature of Claimant: _____

Social Security Number:_____

Please return this form and separate provider form (if claiming child care or respite) within two weeks of program to:

_____
_____
_____
_____

If you have questions, please call _____. Payment will be processed within ___ days of receipt of this completed form.

PAYMENT CANNOT BE PROCESSED WITHOUT SOCIAL SECURITY NUMBER, SIGNATURE OF CLAIMANT AND SIGNATURE OF PROVIDER(S)!